Children's Special Health Services (CSHS) Financial Assistance Application

CSHS provides a limited amount of financial assistance for medical care for qualified Children and Youth with Special Healthcare Needs (CYSHCN), age birth-21. To qualify, please complete this application and provide the following documentation:

- ✓ The most recent tax returns for every person in household who earns income (not required if under the age of 19 *and* attending school).
- ✓ Copy of insurance card (front and back).
- ✓ Documentation of out of pocket insurance premium expense (if applicable).
- ✓ Copy of clinic chart note, note from a medical provider, or a signature of a medical provider on this form (see *medical information* section below) to confirm the child's diagnosis.
- ✓ Signed *Release of Information* form.

Applicant:

NAME: _____ DOB: _____

Main Phone: _____ Alternate Phone: _____

Mailing Address (for correspondence): _____

City: _____ State: _____ Zip: _____

Insurance Company Name *please attach a copy of the front and back of the card*:

_____

Household:

Parent or Guardian NAME: _____

Parent or Guardian NAME: _____

Please indicate how many individuals:

Live in the Household: _____

Earn Income (do not count if under 19 *and* attending school): _____

Receive Dependent Care Services (daycare, preschool, etc.) so a parent can work, look for work, or attend school: _____

Medical Information:

This information must be about the condition for which the applicant is requesting assistance.

Medical Diagnosis: _____

ICD-10 Code (this is required and can be obtained from your child's medical provider): _____

Please provide documentation of the child's condition. This can be a copy of a clinic note, a note provided by a medical provider, or a medical provider's signature below.

I attest the medical diagnosis of the applicant listed above is true and accurate:

_____ _____

Medical Provider Signature Date

Medical Provider Name: _____

Practice Name: _____

Practice Mailing Address: _____

City: _____ State: _____ Zip: _____

Please list the contact information for each provider for which you are seeking CSHS Financial Assistance:

_____ _____

Provider Name or Organization Billing Contact Phone

_____ _____

Provider Name or Organization Billing Contact Phone

_____ _____

Provider Name or Organization Billing Contact Phone

_____ _____

Provider Name or Organization Billing Contact Phone

In signing this form I attest that the information provided is true and accurate to the best of my knowledge.

_____ _____

Legal Guardian/Applicant if 18 or over Date

_____

Print Name